Washington State Department of Social & Health Services
CA Children's Administration

ADOPTION SUPPORT PROGRAM

# PREAUTHORIZATION FOR SERVICES

**SECTION I: TO BE COMPLETED BY THE ADOPTIVE PARENT(S) (PLEASE PRINT)**

| LEGAL NAME OF CHILD (LAST, FIRST, MIDDLE) | SOCIAL SECURITY NUMBER | BIRTHDATE |
|---|---|---|
| | | |

| PARENT(S) NAME | HOME TELEPHONE NUMBER | WORK TELEPHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZI P CODE |
|---|---|---|---|
| | | | |

| SERVICE REQUEST INFORMATION: TYPE OF SERVICE REQUESTED | TO BE PROVIDED BY: PROVIDER'S NAME |
|---|---|
| | |

| FAMILY INSURANCE CARRIER #1 | | FAMILY INSURANCE CARRIER #2 | |
|---|---|---|---|
| COMPANY NAME | POLICY NUMBER | COMPANY NAME | POLICY NUMBER |
| | | | |
| ADDRESS | | ADDRESS | |
| | | | |

Will family insurance cover the above requested service? ☐ No ☐ Yes; if yes, how much: _____

**I am requesting service per above for my(our) child.**

| ADOPTIVE PARENT'S SIGNATURE | DATE | ADOPTIVE PARENT'S SIGNATURE | DATE |
|---|---|---|---|
| | | | |

**SECTION II: TO BE COMPLETED BY THE PROVIDER**

The above named child is seeking service from you for: ☐ Counseling

☐ Medical ☐ Other (specify): _____

Complete the following to facilitate the authorization of the service or you may attach an assessment/report describing the condition and services to be provided. Unless preauthorized by exception with the program manager, fees will be paid at medicaid rates. ☐ **Report attached.**

DIAGNOSIS OF CHILD'S CONDITION

| SERVICE BEGIN DATE | Service will be a total of _____ sessions. $ _____/hour |
|---|---|
| SERVICE END DATE | **OR** The total fee for the service is $ _____. |

BILLING INSTRUCTIONS: When applicable, the insurance company must be billed first. When submitting billings, show the amount the insurance has either paid or denied. An insurance explanation of benefits should accompany the billing. If this is a Medicaid covered service, it must be submitted to Medicaid for payment. Non-Medicaid services must be pre-authorized by an Adoption Support Program manager on this form before initiating services. You may call toll free, 1-800-562-5682, with questions Billings for non-Medicaid covered services are to be submitted to: DEPARTMENT OF SOCIAL AND HEALTH SERVICES, ADOPTION SUPPORT PROGRAM,

| PROVIDER'S SIGNATURE | CREDENTIALS |
|---|---|
| | |

| PROVIDER'S PRINTED NAME | PROVIDER'S TELEPHONE NUMBER |
|---|---|
| | |

| ADDRESS | CITY | STATE | ZI P CODE | PROVIDER'S TAX IDENTIFICATION |
|---|---|---|---|---|
| | | | | |

**SECTION III: TO BE COMPLETED BY THE PROGRAM MANAGER**

1. Child is on:
   ☐ Adoption Support Program OR ☐ Reconsideration Program
2. Has medical insurance been utilized? ☐ No ☐ Yes
3. Is the requested treatment covered by Medicaid? ☐ No ☐ Yes
4. Have other available resources been utilized? ☐ No ☐ Yes
5. **Requested service approved:** ☐ No ☐ Yes

COMMENTS:

| PROGRAM MANAGER'S SIGNATURE | SERVICE END DATE |
|---|---|
| | |

**DSHS 10-214 (REV. 06/2006)**

Route all copies of completed form to Adoption Support Program. ASP will return a copy to provider and to adoptive family.